		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030023

Facility Name: Clearbrook Center

Address: 3201 W. Campbell (Number) Rolling Meadows (City) 60008 (Zip Code)

County: Cook

Telephone Number: 847-870-7711x5065 **Fax #** 847-870-9926

IDPA ID Number: 36-2420176-003

Date of Initial License for Current Owners: 11/01/85

Type of Ownership:

[x]	VOLUNTARY,NON-PROFIT		[ ]	PROPRIETARY		[ ]	GOVERNMENTAL
	[x]	Charitable Corp.		[ ]	Individual		[ ] State
	[ ]	Trust		[ ]	Partnership		[ ] County
IRS Exemption Code	501c3			[ ]	Corporation		[ ] Other
				[ ]	"Sub-S" Corp.		
				[ ]	Limited Liability Co.		
				[ ]	Trust		
				[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Joan Kearney **Telephone Number:** 847-870-7711x5065

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/2002 to 6/30/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Carl LaMell
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Clearbrook Commons # 33023 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	92	Intermediate/DD	92	32,850	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	32,603			32,603	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,603			32,603	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.25%

D. How many bed-hold days during this year were paid by Public Aid?
247 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 11/1/85

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 11/1/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 7/1/2001 Fiscal Year: 6/30/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Clearbrook Center # 0030023 **Report Period Beginning:** 7/01/2002 **Ending:** 6/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	154,415		94,237	248,652		248,652		248,652			1
2	Food Purchase		214,418		214,418		214,418		214,418			2
3	Housekeeping	186,364	100,714		287,078		287,078		287,078			3
4	Laundry											4
5	Heat and Other Utilities			92,358	92,358		92,358		92,358			5
6	Maintenance	41,705	14,905	119,391	176,001		176,001	33,108	209,109			6
7	Other (specify):*											7
8	**TOTAL General Services**	382,484	330,037	305,986	1,018,507		1,018,507	33,108	1,051,615			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,025,119	101,558		2,126,677		2,126,677		2,126,677			10
10a	Therapy											10a
11	Activities	31,179	2,663		33,842		33,842		33,842			11
12	Social Services											12
13	Nurse Aide Training											13
14	Program Transportation			2,360	2,360		2,360		2,360			14
15	Other (specify):*			551,012	551,012		551,012		551,012			15
16	**TOTAL Health Care and Programs**	2,056,298	104,221	553,372	2,713,891		2,713,891		2,713,891			16
	C. General Administration											
17	Administrative	84,139			84,139		84,139	203,815	287,954			17
18	Directors Fees											18
19	Professional Services							18,565	18,565			19
20	Dues, Fees, Subscriptions & Promotions			626	626		626	29,041	29,667			20
21	Clerical & General Office Expenses	47,310	3,110		50,420		50,420	71,922	122,342			21
22	Employee Benefits & Payroll Taxes			470,981	470,981		470,981	49,232	520,213			22
23	Inservice Training & Education							5,675	5,675			23
24	Travel and Seminar			2,387	2,387		2,387		2,387			24
25	Other Admin. Staff Transportation							4,154	4,154			25
26	Insurance-Prop.Liab.Malpractice			47,262	47,262		47,262	2,933	50,195			26
27	Other (specify):*			63,343	63,343		63,343		63,343			27
28	**TOTAL General Administration**	131,449	3,110	584,599	719,158		719,158	385,337	1,104,495			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,570,231	437,368	1,443,957	4,451,556		4,451,556	418,445	4,870,001			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Clearbrook Center #0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			185,765	185,765		185,765		185,765			30
31	Amortization of Pre-Op. & Org.			3,794	3,794		3,794		3,794			31
32	Interest			18,507	18,507		18,507	11,373	29,880			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			23,649	23,649		23,649		23,649			35
36	Other (specify):*											36
37	**TOTAL Ownership**			231,715	231,715		231,715	11,373	243,088			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			266,505	266,505		266,505		266,505			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			266,505	266,505		266,505		266,505			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,570,231	437,368	1,942,177	4,949,776		4,949,776	429,818	5,379,594			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Clearbrook Center # 0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Clearbrook Center

ID# 0030023

Report Period Beginning: 7/01/2002

Ending: 6/30/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Clearbrook Center # 0030023 **Report Period Beginning:** 7/01/2002 **Ending:** 6/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Clearbrook Center # 0030023 **Report Period Beginning:** 7/01/2002 **Ending:** 6/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Clearbrook Center # 0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	0	Clearbrook Lattof Commons	Rolling Meadows	Clearbrook	Rolling Meadows	
None	0	Clearbrook West	Rolling Meadows	CRH, Inc.	Rolling Meadows	
None	0	Clearbrook East	Rolling Meadows	Clearbrook	Rolling Meadows	
None	0	Wright Home	Gurnee	Augustana	Gurnee	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Clearbrook Center # 0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Clearbrook Center # 0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Salaries	11,519,999		$ 148,391	$	2,570,231	$ 33,108	1
2	17	Administrative	Salaries	11,519,999		913,518	913,518	2,570,231	203,815	2
3	19	Professional Services	Salaries	11,519,999		83,208		2,570,231	18,565	3
4	20	Dues,Fees Subscriptions&Promo	Salaries	11,519,999		130,163		2,570,231	29,041	4
5	21	Clerical & General Office Expens	Salaries	11,519,999		322,361		2,570,231	71,922	5
6	22	Employee Benefits & Payroll Taxe	Salaries	11,519,999		220,664		2,570,231	49,232	6
7	23	Inservice Training & Expenses	Salaries	11,519,999		25,435		2,570,231	5,675	7
8	25	Other Admin Staff Transportation	Salaries	11,519,999		18,618		2,570,231	4,154	8
9	26	Insurance-Prop,Liab.Malpractice	Salaries	11,519,999		13,147		2,570,231	2,933	9
10	32	Interest	Salaries	11,519,999		50,977		2,570,231	11,373	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,926,482	$ 913,518		$ 429,818	25

Facility Name & ID Number Clearbrook Center # 0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Industrial Revenue Bonds		x	Construct Building	Variable	6/21/00	$ 3,700,000	$ 3,400,000	11/1/28	variable	$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,700,000	$ 3,400,000			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,700,000	$ 3,400,000			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Clearbrook Center # 0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clearbrook Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030023

CONTACT PERSON REGARDING THIS REPORT Joan Kearney

TELEPHONE 847-870-7711x5065 FAX #: 847-870-9926

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Clearbrook Center # 0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building	50,000	1985	$ Donated	1
2					2
3	TOTALS	50,000		$	3

Facility Name & ID Number Clearbrook Center # 0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	92		1985	1985	$ 4,357,440	$ 108,826	40	$ 108,826	$	$ 1,908,858	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security Doors			1989	2,887	78	38	78		1,045	9
10	Lights			1990	18,120	496	37	496		6,468	10
11	Awning Ladder and compressor			1991	16,686	453	36	453		6,043	11
12	Carpeting			1992	22,645	640	33	640		9,274	12
13	Canopy			1994	35,000	1,057	33	1,057		10,151	13
14	Construction documents			1994	12,250	370	33	370		3,553	14
15	Asbestos Survey and abatement			1995	15,012	462	32	462		3,999	15
16	Architect Fees			1995	21,596	673	32	673		5,777	16
17	Heating and air conditioning			1995	34,230	1,067	32	1,067		9,158	17
18	Interior decorating and new flooring			1995	15,965	498	32	498		4,272	18
19	Electrical work			1995	7,459	232	32	232		2,088	19
20	Build 75 foot ramp			1996	4,300	430	10	430		3,225	20
21	Concrete exit ramp and railings			1996	13,824	463	31	463		2,939	21
22	A/C Compressor			1997	337	34	10	34		219	22
23	Wall Coverings			1998	4,767	477	10	477		2,623	23
24	Carpeting			1998	44,128	2,532	18	2,532		10,387	24
25	Boiler valves			2000	1,444	144	10	144		505	25
26	Pella windows			2000	6,704	268	25	268		938	26
27	Sprinkler system			2000	8,873	444	20	444		1,553	27
28	Replacement windows			2001	6,704	268	25	268		670	28
29	Equipment survey			2001	2,000	100	20	100		250	29
30	Brick wall			2001	700	35	20	35		88	30
31	Gas line			2001	3,018	101	30	101		251	31
32	Kohler generator			2001	12,159	608	20	608		1,520	32
33	Simplex fire alarm			2001	1,952	98	20	98		245	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Clearbrook Center # 0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fuel tank	2001	$ 2,922	$ 146	20	$ 146	$	$ 365	37
38	tile room 313	2001	1,420	71	20	71		177	38
39	pool chemical controller	2001	2,886	289	10	289		723	39
40	HVAC repairs	2001	20,763	1,038	20	1,038		2,595	40
41	Kitchen remodeling	2001	61,419	2,457	25	2,457		6,559	41
42	Recob room tile	2001	1,555	78	20	78		195	42
43	Central Air compressor	2001	15,233	762	20	762		1,905	43
44	Tile	2001	14,760	738	20	738		1,845	44
45	Concrete repair	2001	1,200	120	10	120		300	45
46	AC repairs	2001	14,267	713	20	713		1,782	46
47	Wall protector	2002	14,777	739	10	739		1,478	47
48	HVAC repairs	2002	25,761	2,576	10	2,576	(0)	3,864	48
49	Kitchen remodeling	2002	5,300	530	10	530		795	49
50	AC Compressor	2002	2,500	250	10	250		375	50
51	HVAC repairs	2002	23,430	2,343	10	2,343		3,515	51
52	Fire alarm system	2002	1,576	158	10	158	0	237	52
53	Wallpaper	2002	1,800	180	10	180		270	53
54	Vinyl Floor	2003	3,100	155	10	155		155	54
55	Security Equipment	2003	3,800	190	5	190		190	55
56	Tile	2003	3,100	155	5	155		155	56
57	Pool Repair	2003	8,260	413	7	413		413	57
58	Water Leak Repair	2003	8,562	428	7	428		428	58
59	Doors	2003	976	49	5	49		49	59
60	Tile	2003	3,100	155	5	155		155	60
61	Elevator Motor	2003	2,813	141	5	141		141	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,915,480	$ 135,727		$ 135,728	$ 0	$ 2,024,765	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Clearbrook Center # 0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 153,222	$ 17,100	$ 17,100	$		$ 80,439	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 153,222	$ 17,100	$ 17,100	$		$ 80,439	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1996 Ford bus	1996	$ 43,275	$	$	$		$	76
77	Patient Care	1998 Chevy van	1998	38,435						77
78	Patient Care	1997 Dodge Braun	1998	33,643						78
79										79
80	TOTALS			$ 115,353	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,184,055	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 152,827	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 152,828	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,105,204	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Clearbrook Center # 0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[x]
IN OTHER FACILITY	[ ]
COMMUNITY COLLEGE	[ ]
HOURS PER AIDE	44

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[x]
IN OTHER FACILITY	[ ]
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Clearbrook Center # 0030023 **Report Period Beginning:** 7/01/2002 **Ending:** 6/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 348,847	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		3,992,830	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		19,526	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		158,518	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 4,519,721	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		684,932	11
12	Long-Term Investments			12
13	Land		1,923,067	13
14	Buildings, at Historical Cost		16,078,067	14
15	Leasehold Improvements, at Historical Cost		342,878	15
16	Equipment, at Historical Cost		3,830,019	16
17	Accumulated Depreciation (book methods)		(6,631,004)	17
18	Deferred Charges		178,631	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		224,941	22
23	Other(specify):		139,996	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 16,771,527	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 21,291,248	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 443,301	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		1,004,865	29
30	Accrued Salaries Payable		976,064	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		13,623	33
34	Deferred Compensation		196,799	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Permanently Restricted		60,000	36
37	Due to Temporarily Restricted		165,796	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 2,860,448	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,810,619	40
41	Bonds Payable		3,400,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Permanently Restricted		861,424	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,072,043	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 10,932,491	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,358,757	$ 10,358,757	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,358,757	$ 21,291,248	48

***(See instructions.)**

Facility Name & ID Number Clearbrook Center # 0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,884,134	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,884,134	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(402,733)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Clearbrook net income net of Commons**	877,356	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 474,623	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 10,358,757	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Clearbrook Center # 0030023 Report Period Beginning: 7/01/2002 Ending: 6/30/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,468,901	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,468,901	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	30,620	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 30,620	23
	D. Non-Operating Revenue		
24	Contributions	47,522	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 47,522	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,547,043	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,018,507	31
32	Health Care	2,713,891	32
33	General Administration	719,158	33
	B. Capital Expense		
34	Ownership	231,715	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	266,505	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,949,776	40
41	**Income before Income Taxes (line 30 minus line 40)****	(402,733)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (402,733)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses		12,872	260,786	20.26	3
4	Licensed Practical Nurses		13,306	256,143	19.25	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants		2,796	31,179	11.15	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook		16,730	154,415	9.23	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers		4,563	41,705	9.14	17
18	Housekeepers		21,226	186,364	8.78	18
19	Laundry					19
20	Administrator		2,519	84,139	33.40	20
21	Assistant Administrator					21
22	Other Administrative		95	2,390	25.22	22
23	Office Manager					23
24	Clerical		3,758	47,310	12.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)		15,168	200,213	13.20	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)		126,841	1,264,606	9.97	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Coordinator		1,987	41,287	20.78	33
34	TOTAL (lines 1 - 33)		221,861	$ 2,570,537 *	$ 11.59	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	120	24,000		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	284	21,164		43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Neurological	18	2,160		46
47	Psy/Behavior	193	14,550		47
48	Psychiatric	61	9,064		48
49	TOTAL (lines 35 - 48)	676	$ 70,938		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Kaufman	Vice President	0	$ 40,000
Dave Boggs	administrator	0	44,139
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,139

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,219
Unemployment Compensation Insurance	12,183
FICA Taxes	194,864
Employee Health Insurance	157,814
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension (403b)	52,900
TOTAL (agree to Schedule V, line 22, col.8)	$ 470,980

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Subsciptions	626
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 626

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Staff Conferences	2,387
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,387

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **no**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? **no** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,550** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **no** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **no** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **266,505**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **none** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $

c. What percent of all travel expense relates to transportation of nurses and patients? **100%**

d. Have vehicle usage logs been maintained? **yes**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**

g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Blackman Kallick Bartelstein** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **na**
Attach invoices and a summary of services for all architect and appraisal fees.